

ENROLLMENT FORM FOR GROUP INSURANCE
SECTION TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT)

Name of Employee Last First Middle				Social Security No.		Date of Birth (Mo./Day/Yr.)		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Employee's Address Street				City State Zip Code		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			
Employee's E-mail Address				Phone No. (include area code)					
Name of Employer				Customer Number		Division	Class	Dept Code	
Employer's Street Address				City		State	Zip Code	Employee Work Location	
Date of Hire (Mo./Day/Yr.)		<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time		Employee's Occupation:			Coverage Effective Date (Mo./Day/Yr.)		
Work Status: <input type="checkbox"/> New Hire <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Rehire <input type="checkbox"/> On Layoff/Leave of Absence		Hours Worked Per Week:		<input type="checkbox"/> Hourly Paid <input type="checkbox"/> Annual <input type="checkbox"/> Monthly			Salary \$		
<input type="checkbox"/> Original COBRA Effective Date (Mo./Day/Yr.) _____									
Reason for Enrollment: <input type="checkbox"/> New Coverage <input type="checkbox"/> New Hire First Time Eligible <input type="checkbox"/> Late Enrollee (Statement of Health Required) <input type="checkbox"/> Change in Coverage Amount Requested <input type="checkbox"/> Change in Enrollment Other Than Coverage Amount <input type="checkbox"/> Family Status Change (not applicable to new enrollments) Date (Mo./Day/Yr.) _____									
COVERAGE REQUEST DATA:									
I have received and read a copy of my employer's current announcement of the group plan. I want to be covered under the group plan for the benefits which I am or may become eligible, requested below.									
I request the following coverage:									
Employee Coverage									
<input type="checkbox"/> Basic Life/Accidental Death & Dismemberment (AD&D) (or Core): Coverage Requested \$ _____									
<input type="checkbox"/> Enhanced Optional Life (or Buy up): Coverage Requested \$ _____ (Not to exceed 5x Basic Annual Earnings)									
<input type="checkbox"/> Short Term Disability (STD)									
<input type="checkbox"/> Voluntary Short Term Disability: Coverage Requested \$ _____ (Sold in increments of \$50)									
<input type="checkbox"/> Long Term Disability (LTD)									
<input type="checkbox"/> Dental									
<input type="checkbox"/> Dental Dual Option (Select one option): <input type="checkbox"/> Low Plan <input type="checkbox"/> High Plan									
<input type="checkbox"/> Voluntary Dental									
Dependent Spouse Coverage (Note: Dependent coverage is provided under the same plan the employee has chosen.)									
<input type="checkbox"/> Dependent Spouse Life* (*Amounts will be subject to state limits, if applicable.)									
<input type="checkbox"/> Enhanced Dependent Spouse Life (or Buy-Up):* Coverage Requested \$ _____ (Not to exceed 50% of Employee amount)									
<input type="checkbox"/> Dental/Dental Dual Option/Voluntary Dental									
Dependent Child Coverage (Note: Dependent coverage is provided under the same plan the employee has chosen.)									
<input type="checkbox"/> Dependent Child Life* (*Amounts will be subject to state limits, if applicable.)									
<input type="checkbox"/> Enhanced Dependent Child Life (or Buy-Up):* Coverage Requested \$ _____									
<input type="checkbox"/> Dental/Dental Dual Option/Voluntary Dental									
<input type="checkbox"/> I wish to DECLINE any coverage not checked above for which I may be eligible. For Life, LTD and/or STD coverage, I understand that I will be required to submit evidence of my and/or my dependents' good health satisfactory to MetLife if I request this coverage after my initial period for enrollment has expired. For Dental and/or Dependent Dental coverage, a waiting period may be required before I can enroll. If I request Voluntary Short Term Disability after my initial enrollment period, I understand that I can become covered for no more than \$100 of Weekly Benefit by enrolling during the next enrollment period. Reason for declining employee and/or dependent coverage (i.e. benefits elsewhere, cost, other): _____									

If applying for Dependent coverage (Spouse and Child), complete section below: Number of dependents (including spouse) _____ Name (Last, First, MI) _____ Date of Birth _____ Sex (M/F) _____ Spouse: _____ Child(ren): _____ _____ _____ _____			If dependent children are full-time students in college, vocational or trade school, please complete the following: Child(ren) _____ Name of School _____ _____ _____ _____	
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For employees electing Enhanced Optional Life (or Buy-Up) and Enhanced Dependent Life (or Buy-Up) Insurance, please answer the following question:

Have you been Hospitalized (as defined below) during the 90 days preceding the date of this enrollment form?

Employee
 Yes No

Spouse
 Yes No

Child(ren)
 Yes No

If the answer to the Hospitalization question is "Yes," a Statement of Health form is required for each person answering "Yes."

Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility; intermediate care facility, or long term care facility, or receipt of the following treatments wherever performed: chemotherapy, radiation therapy, or dialysis.

**GEF02-1
ADM**

DECLARATION SECTION

Each person signing below **declares** that all the information given in this enrollment form, including any medical questions, is true and complete to the best of his/her knowledge and belief. Each person understands that this information will be used by MetLife to determine his or her insurability.

The employee **declares** that he or she is actively at work on the date of this enrollment form and, for purposes of any contributory life insurance, that he or she was actively at work for at least 20 hours during the 7 calendar days preceding the date of enrollment. In addition if the employee is not actively at work on the scheduled Effective Date of contributory life insurance, such insurance will not take effect until the employee returns to active work. This does not apply to replacement contracts.

On the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized.

For the Accelerated Benefits Option

Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. Receipt of accelerated benefits may affect eligibility for public assistance and that an interest and expense charge may be deducted from the accelerated payment.

For Changes Requested After Initial Enrollment Period Expires

I **understand** that if life or disability coverage is not elected, or if the maximum coverage is not elected, evidence of insurability satisfactory to MetLife may be required to elect or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase. I also **understand** that if dental coverage is not elected, a waiting period may be required before I can enroll for such coverage after the initial enrollment period has expired.

For Payroll Deduction Authorization By the Employee

I **authorize** my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind it in writing.

Fraud Warning:

If you reside in or are applying for insurance under a policy issued in one of the following states, please read the applicable warning.

New York [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Kansas, Oregon, Washington and Vermont: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All other states:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE (Dependent Insurance is Payable to the Employee)			
The Employee signing below names the following person(s) as primary beneficiary(ies) for any MetLife payment upon his or her death. For any other type of beneficiary, please use a beneficiary designation form available from your employer. Unless designated otherwise, payments will be made in equal shares or all to the survivor. The Employee understands that he or she has the right to change this designation at any time.			
Primary Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)
If the Primary Beneficiary(ies) die before me, I designate as Contingent Beneficiary(ies):			
Contingent Beneficiary Full Name (Last, First, Middle Initial)	Relationship	Date of Birth (Mo./Day/Yr.)	Address (Street, City, State, Zip)

Signature(s): The employee must sign in all cases. Each person signing below acknowledges that they have read and understand the statements and declarations made in this enrollment form.

Employee Signature

Print Name

Date (Mo./Day/Yr.)

Proposed Insured(s) if other than employee and at least 18 years of age:

Other Signature

Print Name

Date (Mo./Day/Yr.)

Other Signature

Print Name

Date (Mo./Day/Yr.)

Privacy Notice

If you submit a request for insurance (enrollment form) we will evaluate it. We will review the information you give to us and we may confirm it or add to it in the ways explained below.

This Privacy Notice is given to you on behalf of **METROPOLITAN LIFE INSURANCE COMPANY**.

Please read this Privacy Notice carefully. It describes in broad terms how we learn about you and how we treat the information we get about you. (If anyone else is to be insured, what we say here also applies to information about him or her.) We are required by law to give you this notice.

Why We Need to Know about You: We need to know about you (and anyone else to be insured) so that we can provide the insurance and other products and services you've asked for. We may also need information from you and others to help us verify identities in order to prevent money laundering and terrorism.

What we need to know includes address, age and other basic information. But we may need more information, including finances, employment, health, hobbies or business conducted with us, with other MetLife companies (our "**affiliates**") or with other companies.

How We Learn about You: What we know about you (and anyone else to be insured) we get mostly from you. But we may also have to find out more from other sources in order to make sure that what we know is correct and complete. Those sources may include adult relatives, employers, consumer reporting agencies, health care providers and others. Some of our sources may give us reports and may disclose what they know to others. We may ask for medical information about you from these sources. The Authorization that you sign when you request insurance permits these sources to tell us about you. So we may, for instance:

- Ask for a medical exam
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about your finances, employment, hobbies, mode of living, work history, and driving record.

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., P.O. Box 105, Essex Station, Boston, MA 02112, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

How We Protect What We Know About You: Because you entrust us with your personal information, we treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We take steps to make our computer data bases secure and to safeguard the information we have.

How We Use and Disclose What We Know About You: We may use anything we know about you to help us serve you better. We may use it, and disclose it to our affiliates and others, for any purpose allowed by law. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service
- Help us process claims and other transactions
- Confirm or correct what we know about you
- Help us prevent fraud, money laundering, terrorism and other crimes by verifying what we know about you
- Help us comply with the law
- Help us run our business
- Process data for us
- Perform research for us
- Audit our business

Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena
- Telling another company what we know about you, if we are or may be selling all or any part of our business or merging with another company
- Giving information to the government so that it can decide whether you may get benefits that it will have to pay for
- Telling a group customer about its members' claims or cooperating in a group customer's audit of our service
- Telling your health care provider about a medical problem that you have but may not be aware of
- Giving your information to a peer review organization if you have health insurance with us
- Giving your information to someone who has a legal interest in your insurance, such as someone who lent you money and holds a lien on your insurance or benefits

Generally, we will disclose only the information we consider reasonably necessary to disclose.

We may use what we know about you in order to offer you our other products and services. We may share your information with other companies to help us. Here are our other rules on using your information to market products and services:

- We will not share information about you with any of our affiliates for use in marketing its products to you, unless we first notify you. You will then have an opportunity to tell us not to share your information by "opting out."
- Before we share what we know about you with another financial services company to offer you products or services through a joint marketing arrangement, we will let you "opt-out."
- We will not disclose information to unaffiliated companies for use in selling their products to you, except through such joint marketing arrangements.
- We will not share your health information with any other company, even one of our affiliates, to permit it to market its products and services to you.

How You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we give your information to anyone outside MetLife.

You Can Get Other Material from Us: In addition to any other privacy notice we may give you, we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please contact us at our website, www.metlife.com, or write to your MetLife Insurance Company, c/o MetLife Privacy Office - Inst, P.O. Box 489, Warwick, RI 02887-9954. Please identify the specific product or service you are writing about.